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Metaphor and Medicine: Narrative in Clinical Practice

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For decades it seems that the art has been slipping away from medicine. Like the ancient Greeks, who lamented the passing of the Golden Age, contemporary physicians, educators, the general public, and especially the sick mourn the loss of the human dimension of medical practice. Fragmentation, subspecialization, lack of continuity, technological demands, burgeoning patient volume, institutional stress, and, most recently, managed care appear to have caused recent generations of physicians to devalue relationship-based medicine in favor of procedures and machines [1, 2].

Commentators have responded to this unfavorable diagnosis with various prescriptions. One the earliest was the "biopsychosocial model," which George Engel put forth as a new paradigm to replace the reductionistic, disease-oriented "biomedical model" with a more holistic, illness-centered perspective [3]. The competency-based initiative for medical education sponsored by the American Association of Medical Colleges and the American Council for Graduate Medical Education is the most recent proposed therapy [4, 5]. This innovative regimen parses the art of medicine into a series of topics and competencies in humanism, professionalism, communication, evidence-based practice, and social responsibility, and it requires medical schools and residencies to develop curricula that teach these competencies.

Dehumanization can best be stated in narrative terms; i.e. nowadays medicine tends to ignore or minimize the role of narrative in illness and healing. Narrative medicine is "medicine practiced with the narrative competency to recognize, interpret, and be moved to action by the predicaments of others" [6]. Medicine is largely about storytelling and interpretation, and narrative, metaphor, and symbol are fundamental tools of the trade [7-9]. Ill persons experience meaning in their illnesses, they see themselves as characters in a life narrative, and they approach medicine as a vast network of healing symbols.

Patients understand their illnesses in a narrative way whether their physicians realize it or not. If this is so, and if physicians ignore or devalue narrative, then health care is bound to suffer. From the patients' perspective, narrative incompetence causes widespread dissatisfaction, distrust, and failed expectations. Within the profession, it leads to the persistent

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belief that something valuable is lost; i.e., the old days were better. Today's doctors are taught to objectify their patients and to remain emotionally detached, but in so doing they may not diminish their ability to heal, they may also harm themselves by developing chronic stress, emotional numbness, and burnout.

This essay is a brief reflection on the centrality of narrative and metaphor in medicine. I begin with the anti-narrative position as stated by Susan Sontag, a non-physician, whose sentiments are similar to, but more eloquent than, many physicians who view medicine as a purely technical enterprise [10]. I then critique Sontag's "strip illness of metaphor" position by citing traditional Navajo medicine, a system of healing built almost entirely on narrative and metaphor. I claim that narrative is (or ought to be) an essential component of contemporary medicine, inextricably bound to the technical or machine-based component, like the two snakes that are entwined on the caduceus. In the final sections of the essay, I provide some examples of the importance of language and metaphor in everyday practice and discuss detachment as a barrier to, and empathy as a facilitator of, narrative medicine.

WHO'S AFRAID OF SUSAN SONTAG?

After surviving a bout with breast cancer in the mid-1970s, the literary critic and novelist Susan Sontag published a book entitled *Illness and Metaphor* [10]. This work was distinguished by its crisp, elegant prose style; by its rich array of literary and historical allusion; and, ultimately, by the sensation it caused among our post-modern intelligentsia. Sontag made two central claims. First, she argued that the disease called "cancer" evokes in the populace a pervasive cultural myth or metaphor. Cancer is an obscene, unspeakable, and shameful condition. The disease is closely related to sin or guilt. People who suffer from cancer are often suspected of having brought it upon themselves ("cancer-prone"). On the other hand, medical practitioners approach cancer with a different metaphor based on military images. Cancer is aggressive and invasive; it seeks to infiltrate and colonize by battering down the body's defenses.

Because of these metaphors, especially the first, people who suffer from cancer experience isolation and shame. They don't talk about their illness. They delay seeking medical care. Their families and friends shy away from them. In *Illness and Metaphor* Sontag also examined the nineteenth century cultural beliefs about tuberculosis and found that they, too, detracted from a "true," i.e., scientific, understanding of the disease. Ten years later, in *AIDS as Metaphor* (1988), the author extended her anti-metaphorical analysis to HIV/AIDS, which, she claimed, had largely replaced cancer as the unspeakable disease in our society because it was associated with homophobia and believed to be a punishment from God [11].

Sontag's central claim in both books is that illness should be stripped of metaphor. She wrote, "My point is that illness is not a metaphor, and that the most truthful way of regarding illness — and the healthiest way of being ill — is one most purified of, most resistant to, metaphoric thinking... human beings can and should think of illness from a purely biochemical or physiological perspective" [10, p. 3]. Thus, there ought not be any personal or existential meaning attached to illness, nor cultural images associated with illness. From this perspective, medicine should avoid metaphor like the plague.

Though elegant in style, Sontag's books are deficient in research and full of faulty reasoning. She fails to place her conclusions about the shamefulness of cancer in an historical context, or to provide data to support her statements that cancer sufferers preferentially fail to seek medical treatment [12]. Moreover, she generalizes from

her analysis of a few supposedly negative cultural metaphors to conclude that, therefore, *all* illness metaphors *must* be negative. Finally, she fails to address the human need to experience one's life as a story and to attribute meaning and context to important life events. She seems to take for granted the reductionistic myth that the more a person approximates a reasoning machine, the better off he or she will be.

As a young primary care physician when I first read *Illness and Metaphor*, I had a few observations of my own about the subject matter. First, it seemed obvious that the monolithic cancer metaphor didn't exist. Yes, of course, some people delayed seeking medical care, or chose to be "noncompliant," because their beliefs make them terrified of the disease or its treatment; but this happened no more often with cancer than with other diseases. Indeed, almost every patient with serious illness has a complex mixture of personal, religious, cultural, and media-based beliefs regarding his or her condition; some positive, some negative; some that contribute to healing, others that might delay it. No matter how eloquently Susan Sontag declared, "Do not attribute a meaning to illness," I just couldn't imagine her claiming many converts. Moreover, I had just returned from spending two years in northern Arizona on the Navajo reservation, where I was the only physician at Lower Greasewood Clinic and Boarding School. Living in the Navajo community, I found myself surrounded by a very effective traditional healing system based almost entirely on narrative and metaphor. It seemed clear that, among the Navajo, poetry could heal. It certainly wasn't harmful. If that is so, I asked, why is it harmful to employ metaphor and meaning in Western medicine?

"MAY I WALK IN BEAUTY"

Among the Navajo, all serious illness results from disharmony. To become sick, a person has somehow fallen out of harmony with himself, his family, his clan, and the network of relationships that constitute the Navajo Way. To be healed is to have that harmony restored. In order to accomplish this, the patient, first, has to consult a diagnostician who, by means of hand trembling or other forms of divination, establishes the cause of the illness. The diagnostician then prescribes an appropriate ceremony or "Sing," which consists of storytelling, chanting, sand painting, and other elaborate rituals that may go on for three to nine days. This formal Navajo healing system is almost entirely symbolic. The ceremonies consist of re-telling myths of the creation and salvation of the Navajo people by gods like Spider Woman, White Shell Woman, and the Hero Twins [13, 14].

There was a seeming paradox in Lower Greasewood. The Navajo community enthusiastically accepted Western medical treatment and flocked to the clinic. Yet, when a person was seriously ill, he or she also undertook the complex arrangements for a traditional healing ceremony. A Sing required the presence of the ill person's extended family and other clan members, who would have to set aside their jobs and other responsibilities to participate in several days of chants, prayers and dances. The family would also have to butcher sheep to feed the participants, and pool their resources to pay the *hataali* or Singer and his assistant. What led them to do all this when the Navajo were entitled to free, state-of-the-art medical care through the United States Public Health Service?

At first I thought the benefits were entirely social (i.e., getting together with friends and family) or psychiatric (i.e., treatment of mental disorders). But with time I realized that an appropriate Sing could "heal" any seriously ill person, even a patient with terminal cancer, because prolonging life isn't necessarily the aim of Navajo medicine. Human beings, like plants and animals and the visible world itself, participate in a cycle of birth, develop-

ment, maturity, and decline. This cycle constitutes the harmonious, natural way of the universe. Attempting to extend an elderly person's life beyond its natural span might well be seen as disharmonious or harmful, rather than healing; what the ceremony would do was to bring the dying person into a harmonious relationship with the important persons and values in his or her life.

Moreover, I learned that, for the Navajo, penicillin shots and arthritis pills were not value-free scientific treatments. Rather, the introduction of Western medicine had caused the Navajo to incorporate its procedures and "ceremonies" into their cultural narrative. For example, they developed the belief that antibiotics (primarily "shots," since tablets were thought to be less effective) were very efficient in alleviating the symptoms of pneumonia, but did not address the disharmony that allowed the person to become ill. When fever and cough were gone, important questions remained: "Why me? Why was I vulnerable to this illness? What does my life mean in the face of this illness?" Thus, even though Western medicine had been incorporated into the patients' cultural expectations, they would need to arrange a "Sing" in order to address the more narrative dimensions of illness; i.e., to re-experience themselves as part of a meaningful story.

ASKLEPIOS AND HIPPOCRATES

I find a parallel in ancient Greek medicine between the narrative or symbolic strand in healing, as exemplified by the Navajo, and the empirical or instrumental focus that we strive for in scientific medicine, and of which Susan Sontag approves. The myth of Asklepios, the god of healing, holds that Asklepios was once mortal, the son of the great god Apollo and a human woman named Coronis. Apollo directed that Chiron, who supervises the interface between life and death, teach his son the skills of healing; and Asklepios became world's most powerful healer, so powerful, in fact, that he saved a man whose life was forfeit to the gods. In retribution, Zeus struck Asklepios dead with a thunderbolt. However, later (perhaps as a result of Apollo's influence at the Olympian court), Asklepios was made immortal and became the god of medicine. In keeping with this mythic narrative, Asklepios healed his patients through the mediation of priests and ceremonies, and utilized as modalities interpretation of dreams and visions.

On the other hand, Hippocrates (470 to 410, BCE), the father of scientific medicine, was no myth. He did, indeed, found a tradition of medicine devoted to naturalistic, empirical explanations of disease. He apparently discarded supernatural causation, and focused on behavioral and environmental intervention. Nonetheless, the oath developed by the Hippocratic school of physicians acknowledges the power of myth and narrative, rather than decrying it; the oath begins by pledging commitment to the symbolic world, "I swear by Apollo the physician, and Asklepios, and Health, and All-heal, and all the gods and goddesses..." I suspect that the Hippocratic physicians were professionals who understood the importance of narrative skills in their day-to-day practices.

The original caduceus of Asklepios, which became the symbol of the medical profession, consisted of a single snake of healing entwined around a staff. However, in the United States relatively recently, we have added a second snake to the caduceus [15]. Although the real historical reason is quite otherwise, I like to imagine that our two snakes represent the narrative (Asklepian) and instrumental or empirical (Hippocratic) strands of medicine, entwined in this unified symbol of the healing art.

They are inextricably bound. Just as the Navajo patient views Western medicine from the perspective of her belief system, thus incorporating antibiotics and surgery into her narrative and rendering them a meaning beyond their strictly instrumental effects, so also any other patient brings his

or her beliefs and values to the words spoken (or unspoken) and actions performed by medical practitioners.

If the physician understands this dynamic, he or she is likely to develop and utilize narrative skills in practicing medicine. Narrative competence leads to better clinical outcomes, e.g., more accurate diagnoses, enhanced adherence to therapy, and greater patient satisfaction. Alternatively, if the physician believes that *real* medicine is confined to the Hippocratic or instrumental dimension, his or her influence on the patient is bound to be less predicable, depending on whether their beliefs happen to be synergistic or antagonistic, or whether they happen to exchange the right words or the wrong words, and so forth. In other words, by subscribing to a culture of medicine based on the belief that medicine is above or beyond culture, the doctor is bound to be a less effective healer.

The following paragraphs suggest a few of the ways that narrative elements — words, images, metaphors, and symbols — influence and structure day-to-day practice, even when physicians may focus their attention elsewhere and have no idea what is happening in the patient encounter, or in their interaction with other health care professionals.

WORDS AND IMAGES

Common words and phrases in medicine reflect a culture that objectifies patients. For example, the term "history taking" reflects the ambiguous position that narrative enjoys in contemporary medicine. "History" implies objectification of the patient's story, suggesting that "it" is an entity we might discover if we search aggressively enough, like a "black box" among the wreckage of a patient's life. "Taking" implies that the doctor violates her patient. She wrenches the story, whisks it away, as if she were pulling a bad tooth or removing a hot appendix. Despite this phraseology, in theory, at least, authorities agree that talking with the patient is the single most important element of diagnosis and the key to effective therapy. *Harrison's Textbook of Medicine* makes this point in its first few pages, before devoting the next two thousand pages exclusively to organ systems and biochemistry.

Another example is the statement, "The patient is a poor historian." The standard medical meaning of this sentence is that the patient is unable to tell the doctor in a coherent or understandable way what is wrong; it blames the patient. However, isn't the doctor the professional whose responsibility it is to reconstruct a relevant illness story? If so, wouldn't it be more reasonable to consider the doctor the historian and the failure, if any, largely the doctor's? After all, he or she is expected to have the communication skills and narrative competence to elicit and understand stories of sickness.

With regard to the iatrogenic suffering caused by inappropriate words in medicine, the internist Eric Cassell coined the aphorism, "Sticks and stones may break your bones, but a word can kill you." Consider casual (or intentional) statements like the following: "You have a time bomb in your chest," "The next heartbeat may be your last," "Your life is hanging by a thread," and "There is no choice. We have to operate." These common examples taken from the field of cardiology, illustrate well how words — perhaps spoken with the best of intentions — can cause iatrogenic harm

THE METAPHORS OF MEDICINE

A number of writers have looked beyond the day-to-day language to discover the basic models or metaphors we use when thinking about medicine [16-17]. There are several such metaphors that to a large extent generate our vocabulary of the patient-physician relationship. Table 1 lists three of the most prominent of these and some of their implications. Contemporary medicine has officially disavowed the parental (or paternalistic) metaphor, which

Table 1. Medical Metaphors

War metaphor	**War statements**
Disease is the enemy	"I treat all my patients aggressively..."
Physician is a warrior captain	"He's a good fighter."
Patient is a battleground	"The war on cancer."
Parental metaphor	**Parental statements**
Disease is a threat or danger	"She's too sick to know the truth..."
Physician is a loving parent	"We don't want him to lose hope."
Patient is a child	
Engineering metaphor	**Engineering statements**
Disease is malfunction	"He's in for a tune-up."
Physician is an engineer or technician	"Something's wrong, doc... you fix it."
Patient is a machine	"We need to ream out your plumbing."

was perhaps the most prevalent way of thinking about the patient-physician relationship in the past. Biomedical ethics teaches us to respect our patients as adult decision makers, rather than simply looking out for their best interests as we would with children. However, the relative demise of paternalism (which at least implied a human, caring interaction) has been accompanied by the rapid advance of the engineering and war metaphors, both of which tend to objectify and dehumanize the patient.

Of course, each of these metaphors is true in a sense. Each sheds some light on the patient-physician relationship, but also casts a shadow. While capturing one characteristic of illness or healing, each one downplays or ignores certain other features. There are also other, more humane, metaphors for medicine; for example, physician-as-teacher, or physician-as-reader or editor. Obviously, we need many such images to capture the truth, but we must understand that none are exclusive, and some are more useful in healing than others.

SYMBOLS OF HEALING

William Osler wrote to his fellow doctors in 1910 about the "faith that heals." In his essay, Osler noted that, while his colleagues viewed the practices and paraphernalia that filled Johns Hopkins Hospital as objective and scientific "givens," patients inevitably experienced them as a vast network of symbols that promote healing. [18] Consider the contemporary hospital — the white coats, stethoscopes, and beepers. The ritual of daily rounds. The ceremony of physical examination. Consider the nuclear magnetic imager as an oven-like oracle that sees inside the soul and one's emergence from this machine a type of resurrection. Or what about the treadmill? A Sisyphean task that patients set their hearts against. All of these procedures, whatever their intended scientific effect, are also symbols or ceremonies that involve the manipulation of symbols. As Osler wrote, "Nothing in life is more wonderful than faith — the one great moving force which

we can neither weigh in the balance nor test in the crucible. Intangible as the ether..." [18]. He went on to explain that the symbolic network of modern medicine generates "an atmosphere of optimism, and cheerful nurses, that work(s) just the same sort of cures as did Asklepios" [18].

DETACHMENT VS. CONNECTION

"Oh, Daddy, can't you give her something to make her stop screaming?" asked Nick.

"No. I haven't any anesthetic," his father said. "But her screams are not important. I don't hear them because they're not important" [19].

I suggest that our modern commitment to detachment and objectivity serves as a barrier to narrative in medicine. In Ernest Hemingway's "Indian Camp," Nick Adam's father makes a nocturnal trip across the lake to deliver an Indian woman who is having a difficult labor. The young Nick goes along for the ride. He experiences a natural empathy with the woman, who is writhing in pain. Yet, his physician father remains detached, explaining that the patient's screams are "not important." He understands the pain from a physiological perspective ("all her muscles are trying to get the baby born"), but considers it a potential distraction. He believes that by listening to the screams, he would compromise his technique.

This quotation illustrates in a dramatic way the tension between detachment and connection in medical practice. Nick's father is evidently a kindly man, yet he believes that emotional vulnerability will impair professional performance. There is, of course, a factual basis to the belief that *too* much involvement with another person's suffering impairs one's functioning. Indeed, the patient's husband, who is wounded and lying on a bunk in the same cabin, eventually commits suicide because he cannot bear the weight of his wife's suffering. Similarly, physicians are ill advised to treat family members and close friends. Yet, there is surely a vast chasm between the pole of ignoring the screams and the opposite pole of being impaired or devastated by them.

Dr. Adams demonstrates what is called *detached concern*. He is concerned about his patient's welfare, yet remains emotionally detached. This stance has become normative for medical education; i.e., we now claim that doctors *should* adopt an attitude of detached concern toward their patients [20, 21]. Yet, unopposed detachment leads to objectification of the patient as a person — and not only the patient's *body*. Since the body is the primary source of "objective" data, the person becomes less relevant to medical practice, except in terms of "soft" concepts like bedside manner. Alternatively, if personal narrative is important, how can one obtain, assess, or interpret such subjective data without developing a type of connection with the patient that appears to be precluded by the term "detached concern"?

I like to characterize this tension between subjectivity and objectivity by borrowing the words *tenderness* and *steadiness* from Thomas Percival, the British Enlightenment physician who wrote the first modern synthesis of medical ethics [22, 23]. In the first chapter, Percival enjoins physicians to "unite tenderness with steadiness" in the care of patients [23]. Under "steadiness" Percival includes the intellectual virtue of objectivity or reason, along with moral virtue of courage or fortitude. By "tenderness" he means humanity, compassion, fellow feeling, and sympathy. In his letters, Percival contrasts the "coldness of heart" that often develops in practitioners who do not cultivate such virtues with the "tender charity" that the moral practice of medicine requires. "This coldness of heart, this *moral insensibility*, should be sedulously counteracted before it has gained an invincible ascendancy" [23]. The contemporary emphasis on detachment and objectivity promotes

coldness of heart and serves as a barrier to narrative medicine.

THE EMPATHIC CONNECTION

The key to finding an appropriate balance between tenderness and steadiness, or subjectivity and objectivity, lies in developing three core personal qualities: (a) *empathy* — the ability to understand accurately the patient's feelings and experience, and to communicate that understanding; (b) *genuineness* — the ability to be yourself in a relationship, without hiding behind a role or facade; and (c) *unconditional positive regard* — the ability to accept and validate patients just as they are. I am unable to discuss these qualities in detail here, but I would like to make a few comments on clinical empathy, which I take to be a teachable and learnable set of skills [24, 25].

In *A Fortunate Man*, John Berger sketches the life of John Sassall, a general practitioner in a rural part in England [26]. For Sassall the doctor's central task is an "individual and closely intimate recognition" of the patient: "If the man can begin to feel recognized — and such recognition may well include aspects of his character which he has not yet recognized himself — the hopeless nature of his unhappiness will have been changed..." [26]. Sassall is acknowledged to be a good doctor "because he meets the deep but unformulated expectation of the sick for a sense of fraternity. He *recognizes* them." In fact, Sassall, "does not believe in maintaining his imaginative distance: he must come close enough to recognize the patient fully" [26]. This recognition of the patient's subjectivity is a function of empathy, which creates the connection that the narrative dimension of medicine requires.

Zinn defined empathy as "a process for understanding an individual's subjective experiences by vicariously sharing that experience while maintaining an observant stance" [27]. There are several possible ways of looking at this "vicarious sharing" or process of recognizing the other. Some writers emphasize the intellectual or cognitive dimension of empathy. The empathic practitioner attends carefully to the other's verbal and nonverbal expressions, interprets them, and then forms hypotheses about the other's subjective experience. The practitioner then shares with the other the fact that he or she has been "heard," while at the same time testing the hypotheses by further questioning: Is this what you really mean? Is that how you really feel?

But there is also a strong *affective* dimension of clinical empathy. You can't know how a patient is feeling in a given situation without, in some sense, actually experiencing that feeling yourself. Spiro expressed the affective aspect of empathy when he wrote, "empathy is more than knowing what we see, it is the emotion generated by the image" [28]. Empathy requires the doctor to be emotionally engaged and "experience the other's attitudes as presences, rather than as mere possibilities" [28]. In other words, interplay of feelings is an essential part of an empathic connection with a patient. One cannot fully recognize or understand the patient without experiencing emotional involvement [22].

CONCLUSION

Illness and healing are inextricably bound to narrative, meaning, and metaphor. The "strip illness of metaphor" metaphor suggested by Susan Sontag, and embodied in contemporary medical practice, damages patient, doctor, and the healing relationship because it promotes detachment, objectivity, and autonomy to the exclusion of connection, subjectivity, and solidarity; and teaches patients and doctors to ignore the power of words and stories to harm, as well as to heal. The Hippocratic and Asklepian dimensions of healing, as suggested by the two snakes of the caduceus, not only inevitably co-exist, but also are potentially synergistic.

In contemporary practice the narrative dimension is often ignored because of our

focus on detachment and objectivity. However, everyday medicine is replete with evidence of the power of language and narrative to heal or to harm. Unfortunately, words and metaphor are more likely to harm when physicians lack narrative competence. Clinical empathy is the doorway to the development of narrative competence. Empathy serves as an avenue by which physicians may "recognize" or connect with their patients, thereby entering into their patients' narrative world.

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